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ABSTRACT

Organizational consultants should attend to several issues when consulting as change agents for organizations. The client will have explicit ideas about the need for help and implicit expectations and fears about the role of the consultant. The consultant must probe, understand, and often change the client's preconceptions and expectations about consulting. In establishing a consultant-client relationship, the consultant needs to be aware of possible defensive reactions, including denial, immediate action demands, and control attempts. Three primary tasks faced in the preliminary phases of consultation are: (1) establishing a trust relationship; (2) making an assessment of the client system; and (3) sharing a futuristic image of the organization. Ideally, organizational consultants should be trained in settings in which they receive intensive supervised experiences in consultation, multiple opportunities to increase self-awareness and individual growth, and exposure to the diversity of organizational types and phenomena. (Author/NRB)

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CONSTRUCTING RELATIONSHIPS FROM WHICH TO CHANGE ORGANIZATIONS

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Constructing Relationships from which to Change Organizations*

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Regardless of the particular modality used in helping organizations and other social systems to change, all such efforts require and work through a relationship between two or more persons. The characteristics of that relationship play a significant part in determining the outcome of the consultative effort. In this paper, I explore some of the important issues organizational consultants should attend to in constructing change relationships with members of organizations.

First, what is meant by "relationship"? When I use the term "consultative relationships" in this paper, I mean the interactions between organizational client and consultant that constitute a helping orientation by the consultant toward the client, in which the focus is on the human needs of the client system, and in which the client works with the consultant toward some end which is identified as being of value to the system, and toward which the consultant can provide special expertise. I specifically do not mean a research relationship, although many of the same principles might apply.

The process of consultation, like most helping relationships, begins "before the beginning." The decision to seek help (which must be distinguished from the decision to be influenced by the helper) is preceded by

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some formulation of an issue needing attention, and which members of the organization are not able by themselves to handle. How the problem is initially formulated, and by whom, will influence the choice of persons from whom help is sought and the future course of the consultation. In addition, organizational representatives approach the consultant with prior expectations of what a consultant ought to do, and these ideas or images may be quite discrepant from those of the consultant. Two factors are relevant here: the client will have explicitly formulated ideas about why help is being sought, though these are often not shared with the interventionist; second, there are also usually present unconscious and implicit expectations and fears about the role of the consultant. The latter will obviously not be directly discussed, but may be revealed to the well-trained consultant in subtle ways and by appropriate inquiry.

Of course the consultant has pre-conceptions and expectations of the client-consulting relationship as well, and often unconscious reactions which may be equally inaccessible. Awareness of one's reactions is one of the most important data sources available to the interventionist, since personal feelings and reactions in any experience-based change effort such as consultation are frequently the most reliable indicators of the nature of the client's problems. They may also be the only information sources available early in the intervention effort.

It is my contention that successful consultation requires a match between the conscious, but more importantly, the unconscious, contract or agenda that the client representatives bring to the consultation and the directions which the consultant has in mind for the organization. These implicit goals can be

identified and changed, of course, and there is room for change of views on the consultant's side as well, but lack of awareness of, and inquiry into, the client's preconceptions of what should or might happen in consultation will impair and severely limit the consultative effort. I think that consultation efforts that end prematurely often do so because the consultant has not probed, understood or changed the client's preconceptions and prior expectations about consulting.

An example may help illustrate these points. In a recent intervention effort based in a large social service organization, I noted to the practicum students I was supervising that I experienced one of the key figures in the institution as being controlling and directive, even though his outward demeanor seemed pleasant and cordial. I centered my explanation of the evidence for this hypothesis around my own reactions, rather than anything that had been directly said or done by him, though a few more explicit clues were discovered on detailed inquiry. Later, in the course of the change project, my initial perceptions were indeed borne out, and the handling of his subtle and later, more direct, controlling behavior was an important issue in managing the project.

Another important issue in constructing effective change relationships is the handling of defensive behavior. Because the initial encounters between client and consultant are characterized by ambiguity and uncertainty, they are fertile territory for defensive reactions. Probably all persons approaching helpers do so with <u>ambivalence</u> and <u>some anxiety</u>; any system that is unambivalently enthusiastic about change is probably suspect. In establishing a relationship with a client, the consultant needs to be aware of the types of defensive reactions he/she is likely to encounter, since the proper handling of these reactions will be important to the early diagnostic understanding

of the system. It is also important to sort out what is situation-specific and what is more deeply ingrained. The types of defensive styles encountered by the consultant early on can be categorized into some commonly occurring themes or patterns. Here I will cite only three illustrative, and frequently occurring, defensive reactions that take place in the organizational consulting context:

1. Denial--Staff members in the initial explorations with the consultant will often frame their problems in ways that minimize discussion of the dysfuctional aspects of the organization. Initial posturing often suggests the image of a well-managed firm with satisfied workers whose management simply wants to be even more magnanimous and benevolent. Rarely are there not underlying problems that also need attention, which, with pleasant but firm confrontation, can be surfaced from the first session;

2. Push for immediate action--By and large, those whose task it is to run organizations and hire consultants are action-oriented, not contemplative, personalities. Most are impatient with a slow-moving, "uncovering" type of approach to creating organizational change. To the extent that this behavioral style interferes with the need to understand the system and what is wrong with it, it is defensive and problematic;

3. Control attempts--Organizational clients are probably more sensitive than most to the issues of the motivation of the helper. Many are experts at determining what is important to a person and appealing to that need. The lure for the consultant may be financial or professional, overt or subtle, but the intent, at least in part, is to control the consultant by controlling what matters to him. It is defensive because it diverts attention from the needs of the client organization to those of the consultant.

I hasten to add that the client representatives are not the only persons susceptible to defensive reactions in a consulting effort. The intervention-

ist is equally liable to distortions and deviations from the helping role. Common consultant defenses include pressures to "perform" and demonstrate usefulness to the client, and awareness of needs other than those of the client, such as one's own interest in learning more about a particular type of organizational setting. The organizational interventionist needs to be self aware in much the same way, and for the same reasons, that a psychotherapist does. In my experience, most organizational consultants and trainees have a lot to learn here, particularly in confronting such issues as dependency and counter-dependency. The general point, simplistically stated, is that it is very difficult to help others confront their problems or harsh realities if you (the interventionist) have not confronted your own. It is also hard to separate your own craziness from that of the client if you are not aware or understanding of your own reactions.

I do not mean to imply that it is necessary or even desirable for the consultant to point out the nature of the defensive reactions of the client (or, for that matter, one's own). The appropriateness of such activities depend on many situation-specific factors, including the client system's health or dysfunction, and the representatives' openness to confrontation. What <u>is</u> important, however, is the consultant's awareness of these reactions, so that she does not prematurely pressure a system or begin an intervention inappropriately. Such awareness requires sensitivity to often subtle psychological dynamics.

A discussion such as this one of defensive styles, self awareness, and diagnosis of behavioral patterns inevitably brings to mind analogies between organizational consultation and the psychotherapeutic relationship. This is both a useful and a limiting comparison, and I would like to pursue it for a few minutes.

Before doing so, I must mention that I approach this task with some misgivings. Drawing analogies between clinical psychology and organizational consultation is apparently a risky undertaking in this arena, a fact dramatically illustrated at last year's [1979] APA convention, in which a panel similar to this one discussed "parallel processes in consultation" to the irate challenge of some organizational psychology colleagues and self-styled critics. That such an intriguing approach to the study of organizational change as parallel processes should inspire such wrath suggests an interesting foray into the sociology of knowledge that unfortunately cannot be pursued here. I will only mention that the antipathy of certain groups to the study of consultation processes on their own terms (i.e. as interpersonal and clinical processes) has a lot to say about where the field is and isn't, and perhaps also, about where its study ought to be based.

What, then, are the similarities and dissimilarities of organizational consultation and psychotherapy? First, the similarities. In both therapy and consultation, the initial encounters with the helper are characterized by uncertainty and ambiguity for both helper and client, stemming from a variety of sources. Secondly, as already noted, most clients are ambivalent about asking for and receiving help, and about the prospects for change, no matter what they may tell you. Furthermore, both are contrived relationships in the sense that they are created for an express helping purpose, and in exchange (most typically) for money or other consideration. They also end, eventually. Other likenesses include the fact that the helping relationship is only a small part of the total "life space" of the clients, and that in both cases there are professional expectations directed by the client and by society to the helper, insisting that certain ethical guidelines be followed, the most basic of which is primum non nocere, "above all, do no harm".

There are important differences between therapy and consultation as well. First, the client populations are not typically the same. Persons seeking help from organizational consultants are more likely to represent so-called "normal" rather than abnormal or culturally atypical populations. Generally, such persons are not experiencing personal psychological problems for which they want help. The expectation, and usually the reality, therefore, is that the helper will focus more on the problems and needs of the organization, rather than on those of individuals within it.

Related to this is the fact that clients representing organizations often do not perceive themselves to be part of the experienced problem. By and large, neurotic patients coming to a therapist have some sense that they are somehow a part of the experienced problem, and are usually willing to entertain a suggestion that, as clients, they will need to do some hard looking at their own behavior. In contrast, organizational members often have very little awareness of, or inclination to study, their own role in the problems at hand. They in fact often consider such inquiries to be intrusions or diversions that are unnecessary and impertinent.

As already noted, organizational representatives are more inclined to action than most mental health clients. They are used to functioning rapidly, and eager to quickly transfer perhaps superficial understanding into concrete action. Next, the persons who approach an organizational consultant often are not the people who are empowered to commit the organization to a change effort. Unlike individual treatment approaches, in organizational work the representatives the consultant sees in the early stages may have been assigned by persons higher in the organization to explore whether to proceed with a particular interventionist, and in fact may be looking over several candidates. Such individuals will be much less invested in the relationship, and much more

tentative in their involvement. Also, organizational clients are less likely than individual clients to perceive status differences between themselves and the change agent. The last difference I want to mention is the distinction between a treatment and a problem focus. Clients with personal problems do not usually come to a therapist with the solution to their problems in mind. They come, generally, to figure out what is wrong. In contrast, the organizational client is much more likely to come in with a particular treatment modality in mind: they want a Scanlon Plan or a Quality of Worklife Committee or a survey and see the consultant as a vehicle to that end. Sadly, there are a lot of change agents who play into this often innapropriate wish to solve problems before they have been identified.

All of this leads us to a more basic question in relationship-establishing: what is a consultant trying to do in the early stages of consultation? In my view, there are three primary tasks the helper of organizations faces in the preliminary phases:

1. Establishing a relationship of trust in which organizational members feel free to discuss their problems and work toward change. In both my own research on the organizational consultation process, and in the voluminous literature on the psychotherapy relationship, trust emerges repeatedly as an important factor (certainly not the only one) of importance to clients;

2. Making an assessment of the client system, both from the perspective of its readiness for change, and its dysfunctional areas, and the consultant's own appropriateness to the effort;

3. Sharing, often implicitly, one's image of what the organization might potentially become, and determining whether such directions are consistent with where people in the organization want to go.

Each of these three consultative tasks works best through a relationship

with the persons seeking help, which communicates both the consultant's benevolence of intent, and (if appropriate) her ability to help. It is not just attention to the so-called process issues that is demanded, it is also understanding the types of persons and defensive patterns the consultant has encountered, determining how best to approach them, and avoiding doing more harm than good to the system in the process. These approaches are by nature clinical (i.e., practice based), and must inevitably be tailored to the idiosyncratic needs of the persons who come before the interventionist.

If any or all of the above is true, it suggests some different directions for the training of organizational consultants than are presently available. In the first place, there are very few institutions where one can get organizational consultative training of any sort. A handful of graduate programs, usually in organizational or community psychology, offer a few token courses in invervention approaches. Supervision in the programs with which I am familiar is limited, and demands that the trainee attend to issues of self-awareness and personality dynamics are rare. Attempting to train students in a climate that is hostile toward issues like the ones I have discussed or skeptical or neutral at best, adds further complication. Ideally, consultants to organizations should be trained in settings in which they can receive intensive supervised experience in consultation, multiple opportunities to increase self-awareness and individual growth, and exposure to the diversity of organizational types and phenomena. There is much room for development of such programs in existing community and clinical programs, but I must admit to multiple doubts about the ability of most organizational psychology curricula to accomodate these perspectives.

In any event, we are a long, long way from a systematic body of knowledge

and practice about changing organizations. We might best proceed by forgetting about all of the gimmicks and favored ploys that seem perennially dominate the OD field, and attempt first to understand what the fundamental building blocks of organizations, individuals, are like. We should not ignore their organizational context, to be sure, but neither should we forget that there are persons within the organizations we seek to change. The most effective consultation relationships appear to be built on understanding--and the successful communication of that understanding to the individuals with whom one is working.

In closing, I would note that clinical psychology has been justly criticized over the last 30 years for its overemphasis on individualistic models, resulting in treatment approaches which ignore important social and contextual variables. Seymour Sarason's presidential address to Division 12 at this convention eloquently and forcefully developed this theme. Organizational interventionists, on the other hand, have by and large ignored individuals, and created change schemes that have little understanding of, or sensitivity to, persons. While organizational consultants might be able to teach a lot to clinicians about social contexts, groups, hierarchy, power, and structures, they could also learn much from clinicians about defenses, ethics, assuming responsibility for a client, and the subtleties and vagaries of individual reactions to change. What bothers me is not so much the complexity of the task, but the failure on the part of the organizational intervention field, and particularly our training programs, to see these issues as important, desirable, or necessary.